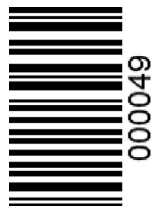




TRANSFER TO GUARANTEED WHOLE OF LIFE COVER PLAN



Before you give us your personal information please note that Irish Life has a Data Privacy Notice. This explains what your data protection rights are and how and why we use your personal information. This is always available on our website at www.irishlife.ie or you can ask us for a copy.

Alterations Team - Policy Review Guaranteed Option

Existing Plan No

Financial Adviser Code

Option 1

Replace your existing plan with the new Guaranteed Whole of Life Cover plan* ☐

You wish to take out a new Guaranteed Whole of Life Cover plan and fully cancel your existing plan

Or

Option 2

Set up the new Guaranteed Whole of Life Cover plan* **and** **alter** the benefits on your existing plan ☐

You wish to take out a new Guaranteed Whole of Life Cover plan and alter the benefits on your existing plan.

Please confirm the revised benefits that you would like to apply to your existing plan:

Revised Premium: €

Life 1 Benefits

From

To

Life 2 Benefits

From

To

1. Plan Owner Details

1(a). Personal Plan Owner 1

Title

Mr ☐

Mrs ☐

Miss ☐

Ms ☐

Other ☐

First Name

Last Name

Date of Birth

 / / (dd/mm/yyyy)

Mobile Number

Email Address

1(b). Personal Plan Owner 2

Title

Mr ☐

Mrs ☐

Miss ☐

Ms ☐

Other ☐

First Name

Last Name

Date of Birth

 / / (dd/mm/yyyy)

Mobile Number

Email Address

1(c). Plan Communications

How would you like to receive your plan communications from us? (for example, your welcome pack, letters and regular statements). Please tick one option:

Plan Owner 1

Online ☐

By Paper Post ☐

Plan Owner 2

Online ☐

By Paper Post ☐

Address - Plan Owner 1

Address - Plan Owner 2

If you choose to receive plan communications by paper post, the address of the 1st plan owner will be used for this purpose.

2. Life Assured Details (if different from Plan Owner)

2(a). Life Assured 1

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First Name

Last Name

Date of Birth / / (dd/mm/yyyy)

2(b). Life Assured 2

Title Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First Name

Last Name

Date of Birth / / (dd/mm/yyyy)

NOTE: The Life cover amount cannot exceed the lower of your current Life cover amount or €30,000

3. New Guaranteed Whole of Life Cover Details

Life Assured 1 - Cover amount*: €

Life Assured 2 - Cover amount*: €

***Life cover is the only benefit included in the Guaranteed Whole of Life Cover Plan. You will automatically be provided cover on the same basis (joint life / dual life) as the existing plan.**

Debit date must be from 1st to 28th of month

Premium** € What day of the month do you want your Direct Debit taken?

Frequency of Direct Debit: Every Month ☐ Every 3 Months ☐ Every 6 Months ☐ Every Year ☐

Plan Start Date: This plan will commence with effect from the review date of your existing plan or, if later, the date of receipt of all requirements.

If this new Guaranteed Whole of Life Cover plan is to be used for Inheritance tax purposes please tick this box ☐

In order for your policy to qualify under inheritance tax planning, please ensure that the policy particulars meet the current Revenue guidelines

Important notes:

1. **The quote provided in your Policy Review Options letter takes in to account any loadings / special terms that were applied on your existing plan.
2. The information we have on our systems under your existing plan was used as the basis for any calculations.
3. If your existing plan is assigned we will require a release of assignment **before** processing this application and issuing the new plan.

4. Declaration of Insurer / Financial Adviser:

I hereby declare that in accordance with Regulation 6(1) of the Life Assurance (Provision of Information) Regulations, 2001,

Customer's name(s)

Address(es)

has/have been provided with the information specified in Schedule 1 (Customer Information Notice) to those Regulations and that I have advised the customer(s) as to the financial consequences of replacing an existing plan with this plan by cancellation or reduction, and of possible financial loss as a result of such replacement.



Please sign and date

Signature of Financial Adviser

Date (dd/mm/yyyy)

5. Declaration

I confirm that I have received in writing the information specified in the Declaration of Insurer/Financial Advisor above. I understand and agree that my new plan contract is based on this application and declaration, the terms and conditions of this policy and all declarations and information already provided on my existing plan.

I consent to Irish Life obtaining information if needed for the purposes of processing a claim, from or sharing information with

- Any doctor who at any time has attended me concerning anything which affects my physical or mental health
- Any health professional for the purpose of processing my application

I agree this authority will stay in force after my death. I agree that this information (including any medical data) can be held for six years.

I confirm I have been informed about the Irish Life Data Privacy Notice and where to get this.

Signed:

Plan Owner 1

Date (dd/mm/yyyy)

Plan Owner 2

Date (dd/mm/yyyy)

If different from above:

Life Assured 1

Date (dd/mm/yyyy)

Life Assured 2

Date (dd/mm/yyyy)



Please sign and date

6. Optional Consent



Please sign and date

Consent to Sharing with Other Companies in the Irish Life Group

I agree to Irish Life Assurance sharing my personal information (excluding my personal health information) with other companies within the Irish Life Group, such as Irish Life Health. I understand this is to assist in developing combined customer services (for example, access to services from different Group companies on one online platform). This is an area that will continue to improve with a view to adding new customer engagement offerings.



Please sign and date

You can change your mind at any time and opt-out of any further sharing by emailing dataprotectionqueries@irishlife.ie or writing to Irish Life Data Protection Team. If you opt-out we will keep a record of your instruction to opt-out.

Plan Owner 1 I agree ☐ I don't agree ☐

Plan Owner 2 I agree ☐ I don't agree ☐

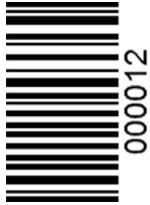
If different to Plan Owner

Life Assured 1 I agree ☐ I don't agree ☐

Life Assured 2 I agree ☐ I don't agree ☐



Irish Life



Your Irish Life Plan Details

Please complete **all** the fields in this Section

Plan Number(s)

If this mandate is to cover more than 3 plans, please attach separate instructions.

Name of Plan Owner(s)

Direct Debit collection date

 of the month (1st to 28th only)

Payment frequency

Monthly ☐

Quarterly ☐

Half Yearly ☐

Yearly ☐

SEPA DIRECT DEBIT MANDATE

Please complete all the fields below marked * and return this mandate to Irish Life

Name and address of the payer:

* Name(s) of Account Holder(s)

Address of Account Holder(s)

BIC

* IBAN

Your BIC and IBAN can be found on a recent bank statement



* Signature(s)

* Date of signing

Please sign and date

By signing this mandate form, you authorise (A) Irish Life to send instructions to your bank to debit your account and (B) your bank to debit your account in accordance with the instruction from Irish Life. As part of your rights, you are entitled to a refund from your bank under the terms and conditions of your agreement with your bank. A refund must be claimed within 8 weeks starting from the date on which your account was debited. Your rights are explained in a statement that you can obtain from your bank.

For Office Use only

UMR

Creditor Identifier

Type of payment

Recurrent ☒

Creditor's name and address